Form 219 Revised 6/2007

Utah Labor Commission
Division of Industrial Accidents
160 East 300 South, 3rd Floor - P.O. Box 146610
Salt Lake City, UT 84114-6610
(801) 530-6800 - (800) 530-5090 - Fax (801) 530-6804

PERMANENT PARTIAL DISABILITY COMPENSATION AGREEMENT

(MUST BE TYPED OR PRINTED)

Applicant's Name _____ DOI _____

Street Address _____ Social Security Number _____

City/State, Zip _____ DOB _____

Employer _____

Insurance Carrier/Adjusting Service Address_____

City/State/Zip _____ Telephone _____ Fax _____

Temporary Total Disability (TTD) Total Paid: _____.
_____ **No Lost Time. (If no lost time, please attach verification of salary at the time of injury.)**
Total Number of Lost Work Days: _____ .

Temporary Partial Disability (TPD) paid _____ for a total of _____ of which _____has been paid.
Total Medicals Paid to Date _____.

Pursuant to the attached medical report and the applicable law, the applicant is entitled to **Permanent Partial Disability Compensation (PPD)** at the rate of $ _____ per week, commencing _____ for _____ weeks, totaling $ _____, for a _____ % impairment of the _____ due to his/her industrial injuries, (of which $ _____ has been advanced).

In consideration of the above payments, as provided by law, the claimant hereby accepts the compensation paid to date and agrees with the permanent partial impairment rating shown above. However, the Labor Commission shall retain continuing jurisdiction to modify awards as provided by law. Medical expenses incurred as a result of the industrial injury are the continuing obligation of the employer/carrier. For injuries occurring on or after April, 30, 2007, medical care becomes a lifetime benefit so long as the insurance carrier/employer is billed within one year from the date of each medical service. The prior three (3) years statute of limitations if no medical care was incurred or billed within three (3) years still applies to injuries occurring between July 1, 1988 and April 30, 2007. Accrued amounts of compensation will be paid in a lump sum. The remaining amounts will be paid as due.

It is understood that this agreement becomes binding and effective only when it is approved by the Labor Commission.

_____ _____
Applicant's Signature Date Adjustor's Name (Please type or print)
(Date sent to Applicant _____)

Adjustor's E-mail Address _____

Adjustor's Signature _____Date _____

The above Compensation Agreement has been reviewed and is approved by the Labor Commission. Attorney's fees of $_____should be deducted from the amounts owing and paid by the carrier/employer to the attorney _____.
(Form 152 must be filed) **(Please type or print)**

_____
Labor Commission Date

NOTE: Compensation is tax exempt for Federal and State Income Tax purposes.

ADJUSTOR NOTE: Required documentation: 3 copies of the signed agreement and 1 each of the Forms 122, 123, 141 and the PPI rating – highlighted (5th Edition). No Lost Time will require proof of wages. If unsigned by applicant, must have explanation. Pre-addressed return envelopes (typed) for yourself and the claimant are required.